IMMUNIZATION ORDER FORM

Section I - Patient Questionnaire

Question	No	Yes	Don't know
1. Are you sick today?			
2. Do you have a fever today?			
3. Do you have any allergies? (If "Yes," please check those you have that are listed below and write in any that are not.) ☐ Eggs ☐ Thimerosal ☐ Neomycin ☐ Gelatin ☐ Rubber or latex ☐ Preservatives ☐ Drugs: _____ ☐ Other: _____			
4. Do you have a history of an adverse reaction to any vaccines in the past?			
5. Do you take a blood thinner line Coumadin, or do you have a bleeding problem?			
6. Do you have a chronic Illness? If "Yes," please state what it is:			
7. Do you, or does any person who lives with you or acts as a care-giver, have cancer, keukemia, AIDS, transplantation, or any other immune system problem?			
8. Have you, or any person who lives with you or acts as a care-giver, taken cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments in the past 3 months?			
9. Have you received a transfusion of blood or plasma, or been given a medicine called immune (gamma) globulin in the past year?			
Female patients only:			
10. Could you be pregnant?			
11. Is there a chance that you could become pregnant in the next 3 months?			
12. When did your last menstrual period begin? **Date:**			
Patient's signature			

Section II - Vaccine Information Statements Provided to the Patient

Subject	Number	Source	Updated
☐ Hepatitis A (Hep A)		CDC	25 Aug 98
☐ Hepatitis B (Hep B)		CDC	9 Aug 00
☐ Influenza		CDC	14 Apr 00
☐ Measles, mumps, rubella		CDC	16 Dec 98
☐ Pneumonia		CDC	29 Jul 97
☐ Polio, injection		CDC	1 Jan 00
☐ Tetanus-diphtheria (Td only VIS June 94)		CDC	15 Aug 97
☐ Varicella (chickenpox)		CDC	16 Dec 98

Section III - Vaccine Orders

	Date last dose (LD) or series complete (SC)	Vaccine name	Dose (ml)	Route	Manufacturer and lot number	Site	Nurse's initials
☐		Diphtheria-Tetanus (dT)	0.5	IM			
☐		Hepatitis A # ____ of ____.	1.0	IM			
☐		Hepatitis B # ____ of 3. Booster # ____.	1.0	IM			
☐		Influenza	0.5	IM			
☐		MMR	0.5	SQ			
☐		Pneumonia	0.5	SQ			
☐		Polio injectable eIPV # ____ of ____.	0.5	SQ			
☐		Varicella # ____ of 2. (Record not required.)	0.5	SQ			
☐		PPD (See PPD/Anergy Sheet.)	0.1	ID			

Signature of providers authorizing vaccine orders

Patient Identification:

Ordered by:	Date
☐ Allergy/Immunization Clinic ☐ Occupational Health Clinic ☐ Reserves	
Administered by	Date

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1 Feb 02

Previous editions are obsolete.